CORRECTIONAL HEALTH SERVICES
MENTAL HEALTH SERVICES

DISCHARGE SERVICE NEEDS

PATIENT'S NAME: FIRST Jason LAST: Reyes B&C #: 384 06 02628

Declined Discharge Planning Services:

☐ Yes, Date: NO

Borough of Residence Following Discharge:

☐ Manhattan ☑ Brooklyn/Staten Island
☐ Bronx ☐ Queens

Armed Forces:

☑ No ☐ Yes If, Yes: ☐ Honorable D/C or ☐ Other than Honorable

Current DSM-IV Diagnosis:

AXIS I: [redacted]

AXIS II:

XIS III: [redacted]

Psychotropic Medication:

[redacted]

SPMI: ☑ NO ☐ YES

Community Treatment:

[redacted]

As Per The Patient:

☐ Monthly Income: $840 monthly or
☐ Plan of Support:

Community Services Currently in Place:

[redacted]

Entitlements:

[redacted]

Case Management:

[redacted]

Homeless Upon Discharge:

[redacted]

MICA:

[redacted]

State Sentenced:

[redacted]

Specific Referral(s):

+ Jayson Reyes
NAME AND APPROVED SIGNATURE

+ 5/30/06
DATE

C. Jorge LMSW
NAME AND SIGNATURE

5/30/06
DATE

Tomik Smith
NAME AND SIGNATURE

5/31/06
DATE

Utilization Management: Initial Review

1. **Treatment Plan Appropriateness:**

   A. Are the symptoms/problems clearly identified? ☑ Yes ☐ No

   B. Do the goals correspond with the symptoms/diagnoses? ☑ Yes ☐ No

   C. Are the goals achievable? ☑ Yes ☐ No

   D. Do the objectives correspond with the goals? ☑ Yes ☐ No

   E. Are the objectives observable/measurable? ☑ Yes ☐ No

2. **Treatment Recommendations:**

   A. Is the patient being treated at the appropriate level? ☑ Yes ☐ No

   B. Is the patient motivated/responsive to treatment? ☑ Yes ☐ No

3. **Discharge Service Needs Plan Recommendations** *(check all that apply):*

   ☑ Discharge service needs plan is appropriate to the treatment plan

   ☑ Discharge service needs plan approved

   ☐ Modify treatment or discharge service needs plan: *(specify)* _____

   _____

   _____

   ☑ Planned date of discharge from treatment pending courts

   ☑ Refer to next Utilization Management Review after approved number of sessions.

   ☑ Date of next review 6/27/06

Additional Comments:

Utilization Management Reviewer(s):

REVIEWED AND APPROVED BY LICENSED CLINICAL SUPERVISOR NAME	SIGNATURE	DATE
David Jurich, PhD		
REVIEWED AND APPROVED BY SUPERVISOR NAME	SIGNATURE	DATE
		5/31/06

CHS [illegible]

NYC Department of Health & Mental Hygiene
MENTAL HEALTH INTAKE FORM

Patient's Name: Reye Juan

Book & Case Number: 749 06 02628

NYS ID Number: 04734412Y

DATE	BUILDING & HOUSING AREA	DATE OF BIRTH	AGE	ETHNICITY
3/6/06	MIC - D3	1/31/83	23	Latino

ADDRESS [redacted]

PRIMARY LANGUAGE [redacted] | ABILITY TO SPEAK ENGLISH [redacted] | Interpreter Needed? [redacted]

EMERGENCY CONTACT PERSON [redacted]

EMERGENCY TELEPHONE NUMBER [redacted]

PATIENT REFERRED BY: Med

PRESENTING PROBLEM
(Include source of referral and patient's complaint)

Rf by medical for MH [illegible] [illegible] [illegible] [illegible] [illegible]

[illegible] with follow through [illegible] [illegible] medical intervention only, [illegible] [illegible]. Follow through has not yet [illegible] the [illegible]

HISTORY OF PHYSICAL AND/OR SEXUAL ABUSE

A) Evidence of physical abuse to patient? ☐ YES ☒ NO

B) Evidence of sexual abuse to patient? ☐ YES ☒ NO

C) Evidence of physical abuse by patient? ☐ YES ☒ NO

D) Evidence of sexual abuse by patient? ☐ YES ☒ NO

SCREENING

Question	NO	YES	Comments
1. Are you experiencing depression, anxiety, or hallucinations?	[redacted]	YES	[redacted]
2. Have you experienced any of these symptoms in the past?	[redacted]	YES	
3. Have you had any previous mental health treatment?	[redacted]	YES	[redacted]
4. Has anyone in your family ever been hospitalized for mental illness?	[redacted]	YES	[redacted]
5. Has anyone in your family taken medication for emotional problems?	[redacted]	YES	
Do you or have you ever used alcohol or drugs? *(If yes, quantity, duration and type of drugs)*	[redacted]	YES	[redacted]
7. Have you ever tried to hurt yourself? *(If yes, give reason, method, precipitant, and whether hospitalized)*	[redacted]	YES	
8. Are you thinking about hurting yourself? *If yes, Why, and Do you have a plan?)*	[redacted]	YES	
9. Do you see any other alternatives or solutions to the problems?	[redacted]	YES	
10. Is there any history of family members trying to hurt themselves?	[redacted]	YES	
11. Have you ever hurt anyone when you were angry or upset?	[redacted]	YES	
12. Are you planning to hurt someone? *(If yes, Who?)*	[redacted]	YES	

13. What you you do when you get upset? *(Describe coping mechanisms)* [redacted]

14. What are some recent stressors? *(Include reason for incarceration, punitive segregation time, or family/community issues)* This [illegible] / incarceration [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] - 6/5 [illegible]

15. Describe significant medical history [illegible]

DHS 290 (Rev. 6. 04)

NYC 0000058

This page redacted

THE CITY OF NEW YORK

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Michael R. Bloomberg
Mayor

Thomas R. Frieden, M.D., M.P.H.
Commissioner

nyc.gov/health

DISCHARGE SUMMARY – AFTERCARE LETTER

LAST NAME: Reyes
FIRST NAME: Jason
B/C#: 349-06-02628
FACILITY: NIC - Dorm - 3

NYSID#: 04704423Y
DATE OF INCARCERATION 02/11/06
RELEASE DATE: 06-09-06

[4] Pt had declined DCP Services
DIAGNOSIS(s) Redacted

MEDICATION

[ ] Prescriptions
[4] Pt not receiving medication while incarcerated
[4] Medication – Medical only
[ ] Medication refused
[ ] No meds dispensed at release: _____ (state reason)
[ ] Names of medication and dosages: _____

MEANS OF RELEASE

[4] Planned release
[ ] State prison/state jail
[ ] Release from Court: _____ (state type)
[ ] Unplanned release from RI _____ (state type)

SERVICES SECURED PRIOR TO RELEASE

[4] Community Services Brochure provided
[ ] Medicaid Application
[ ] DHS Referral
[ ] State Facility Referral
[ ] Borough LINK – Date of acceptance: _____
[ ] Brooklyn EAC LINK
[ ] Queens VOA
[ ] Transportation
[ ] Medication Grant Program Care provided
[ ] Public Assistance Application kit & referral
[ ] NYC HRA 2000 Application
[ ] Referred for Civil Hospitalization
[ ] NYC FEGS
[ ] Bronx Fordham Tremont
[ ] Other:
[4] Other: The Client will Return to 1866 60th Street Apt-3, New York, N.Y. Girl Friend - Roe Lopickelw - (646) 696-0554

[4] Community Treatment Provider(s): (specify name of providers, whether appointment was made or just referral, time, date and location of appointment and any other relevant information.)

The Client F/low-up W/ Private Physical Therapy at ONE-ON-ONE.

Patient: Jason Reyes Date: 6-09-06

Discharge Planner/Nurse/Clinician: Mary Turner Date: 6/9/06

THE CITY OF NEW YORK

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Michael R. Bloomberg
Mayor

Thomas R. Frieden, M.D., M.P.H.
Commissioner

nyc.gov/health

AKA JAYSON

DECLINATION OF DISCHARGE PLANNING

NAME: Jason Reyes

NYSID #: 04704424

B/C #: 349·06·02628

FACILITY: NIC - Annex Dorm 3

DATE: 06·06·06

This form serves to demonstrate that while I have been offered discharge planning services, I choose not to participate at this time. I am aware that I may seek assistance for discharge planning at any future point by notifying a member of the Mental Health Department.

I choose not to participate in the following:

- [✓] All Discharge Planning Services
- [ ] HRA Prescreening
- [ ] Medicaid Application
- [ ] Public Assistance Program, if SPMI
- [ ] HRA 2000, if SPMI
- [ ] Transportation, if SPMI or likely SPMI
- [ ] Boro LINK Placement, if SPMI
- [ ] Department of Homeless Services referral
- [ ] Veterans referral
- [ ] Medication upon release
- [ ] Medication Grant Program Participation
- [ ] Community Mental Health Placement
- [ ] SPAN Brochure
- [ ] Discharge Planning Rights Brochure
- [ ] **Disclosure of Medical Records to BRAD H Monitors**

PATIENT'S SIGNATURE: Jason Reyes SSO

DATE: 06-06-06 a840.w

STAFF'S PRINTED NAME: Monique Anderson

STAFF'S SIGNATURE: Monique Anderson

DATE: 06-06-06

The above named patient has indicated his/her choice to decline all or some discharge planning services, and he/she has elected not to sign this document.

Staff's signature: _____ Date: _____

Witness: _____ Date: _____

PHYSICAL THERAPY PROGRESS NOT

Name: Reyes, Jason

[redacted]: 349 06 02628

D/C 6/9/06 TS

DOB: 11/17/83

Clinic Name: PT

Physician: D3

MD Diagnosis: RSD

Contraindications / MEDS: (L) foot 718 331-8751

Exercises	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
	5/9	5/24	5/31	6/7	6/12					
c̄	✓									
Tens (LBP)		✓	✓	✓	D/C					
MHP		✓	✓	✓						
man		✓	✓	✓						
Therapist Initials	[illegible]	[illegible]	[illegible]	[illegible]						

D/C pt transferred [illegible] [illegible] possibly replaced [illegible]

Physical Therapist Signature: [illegible] M.P.T.

5/24/05 - Pt has been ō ... results; pt has s/s of RSD to the Ⓛ medial/lateral/plantar s. of foot c̄ hyper pain reaction to lite touch even on affected areas; currently tx for LBP pain relief c̄ trunk massage (posterior), pain relief attempt. will try tx recommended in P.T. magazine for RSD that recommends TENs to the associated spinal nerve. contralateral electrode placement [illegible]

5/31/06 - Recent studies indicate use of TENS c̄ acupuncture being employed. parameters to be high/low c̄ contralateral spinal e placement and LE trigger points employed (to knee, between fib/tib), 10 pt recd 30 min.; reviewing pt reaction and cont P.T. [illegible]

6/8/06 - Pt possible D/C; provided clinically evidence for RSD tx. cont PT if held. [illegible]

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name REYES, JASON DOB

FROM Correctional institution Inmate no.

Referred to Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

Date Referring Physician Phone Approved

Consultation, findings and recommendations:

Pt has ... 2° to work ... injury

Date ... Physician

NYC 0000064

Reminder: Fully Complete the Problem List

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name _____ DOB _____

FROM _____
Correctional institution Inmate no.

Referred to _____ Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

Date _____ Referring Physician _____ Phone _____ Approved _____

Consultation, findings and recommendations:

Date _____ Physician _____

CHS 9214 (Rev. 4/94) *Reminder: Fully Complete the Problem List*

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Leave blank for hospital use

PT

Patients' Name REYES, JASON DOB 1/13/83

FROM NIC 03 / 3490602628
Correctional institution Inmate no.

Referred to PT Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings: 23 YO M HX OF

Diagnosis, treatment and medications by C.H.S.: RSD REFLEX SYMPATHETIC DYSTROP. SINCE SEPT 2002

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings: BILATERAL LEG PAIN + WEAKNESS

HYPERASTHESIA TO (L) HEEL

Request: PT FOR ROM TO LOWER EXTREMITIES (AS TOLERATED)

Date 5/4/06 Referring Physician Thomas Schwaner, PA Phone ______ Approved Harjinder Bhatti, MD

Consultation, findings and recommendations:

NYC 0000066

Pt has report of RSD, 2° to work related injury. s/s of RSD to (L) foot m/l and plantar surface c̄ ↓ AROM @ ankle complex evident. pt has hyperesthesia in (L) LE c̄ cogwheel oscillations evident when transferring w. Bing or walking. gait is impaired by RSD c̄ ↑ (8/10) pain brought on with W.B. Tx to ↓ pain c̄ physical agents (U.S. heat) return to P.T.
Syndrome

Date ______ Physician ______

Reminder: Fully Complete the Problem List

IS-C14 Rev

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

P1
(2 weeks)

Patients' Name Reyes Jasun DOB 1/13/83

FROM Nic Dr A / 3Y9061262B
Correctional institution / Inmate no.

Referred to Neurology Ward / Clinic

Hospital BVH / Clinic no.

Chief complaint or findings: 23 y/o → with H/o Reflex sympathetic dystrophy discharge from BVH 4/18/06 recommended F/u Neuro in 2 w/s.

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Meds Neurontin 300 → TID
Cymbalta 40 → daily
Lidoderm patch q12h prn
Oxycontin SR 10 → PO q12h
Allergy, Fentanyl

Request:

(HABIB KAMKHAJI, M.D.)

Date 4/18/06 Referring Physician [signature] Phone 1252 Approved Rajeev L. Ashar, MD

Rajeev L. Ashar, MD

Consultation, findings and recommendations:

ate _____ Physician _____

3 5014 (Rev. 7-4)

Reminder: Fully Complete the Problem List

CORRECTION DEPARTMENT
CITY OF NEW YORK

COMMAND: NIC

DATE: 6/1/06

SPECIALTY CLINIC REFUSAL FORM

PART A

INMATE'S NAME: Reyes Jason

BOOK AND CASE NUMBER: 3490602628

CLINIC:

CLINIC LOCATION: Bellevue

APPOINTMENT DATE: 6/1/06

I REFUSE TO GO TO MY SCHEDULED MEDICAL TREATMENT ON THIS DAY:

(SIGNATURE OF INMATE)

WITNESSED BY (CLINIC STAFF):

Habib Kamkhaji, MD
(PRINT NAME)

(SIGNATURE OF STAFF MEMBER)

6/1/06
(DATE)

REASON FOR REFUSAL

CORRECTION DEPARTMENT
CITY OF NEW YORK

CLINIC SITE:

DATE: / /

SPECIALTY CLINIC REFUSAL FORM

PART B

INMATE'S NAME:

BOOK AND CASE NUMBER:

CLINIC:

APPOINTMENT DATE: / /

I REFUSE TO HAVE MY SCHEDULED MEDICAL TREATMENT ON THIS DAY.

(SIGNATURE OF INMATE)

REASON FOR REFUSAL

INTERVIEW CONDUCTED BY (PRINT NAME) | RANK | SHIELD # | SIGNATURE

CORRECTION DEPARTMENT
CITY OF NEW YORK

COMMAND: NICDU

DATE: 6/1/06

SPECIALTY CLINIC REFUSAL FORM

PART A

INMATE'S NAME: Reyes Jason

BOOK AND CASE NUMBER: 3490602628

CLINIC:

CLINIC LOCATION: Bellevue

APPOINTMENT DATE: 6/1/06

I REFUSE TO GO TO MY SCHEDULED MEDICAL TREATMENT ON THIS DAY:

(SIGNATURE OF INMATE)

WITNESSED BY (CLINIC STAFF):

Habib Kamkhaji, MD
(PRINT NAME)

(SIGNATURE OF STAFF MEMBER)

6/1/06
(DATE)

REASON FOR REFUSAL

CORRECTION DEPARTMENT
CITY OF NEW YORK

CLINIC SITE:

DATE: / /

SPECIALTY CLINIC REFUSAL FORM

PART B

INMATE'S NAME:

BOOK AND CASE NUMBER:

CLINIC:

APPOINTMENT DATE: / /

I REFUSE TO HAVE MY SCHEDULED MEDICAL TREATMENT ON THIS DAY.

(SIGNATURE OF INMATE)

REASON FOR REFUSAL

INTERVIEW CONDUCTED BY (PRINT NAME) | RANK | SHIELD # | SIGNATURE

NYC HEALTH AND HOSPITAL CORPORATION

CORRECTIONAL HEALTH SERVICES

AFTER CARE LETTER

BC# 3490602621

AFTER CARE LETTER

Date: 6/8/06

To Whom It May Concern:

Patient REYES, JAYSON has been under our care for the following conditions:

I. Health Problems

II. Treatments, Medications, Date, Follow-Up Needs

Reflex Sympathetic Dystrophy → Neurology f/u at B[illegible]

[illegible]

Follow-up care is required for the above conditions(s)

Clinic Tel. # [illegible]

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name REYES, JASON DOB 1/3/53

FROM NIC / 3490602628
Correctional institution MEDICAL Inmate no.

Referred to [redacted] Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.: PATIENT STATES WHEEL CHAIR THAT WAS GIVEN TO HIM FROM BELLEVUE HOSP WAS PLACED IN STORAGE ON 5/25/06

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request: PLEASE RETURN IT TO PATIENT IF POSSIBLE

THANK

THANK

Date 5/30/06 Referring Physician Thomas Schwaner, PA Phone _____ Approved _____

Consultation, findings and recommendations:

ate _____ Physician _____

NYC 0000071

S 5011 (Rev. 1-94)

Reminder: Fully Complete the Problem List

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE CHS FORM

MEDICATION ORDER SHEET

USE BALL POINT PEN AND PRESS FIRMLY

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES

DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
INDICATION						
3						
DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
INDICATION						
DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
INDICATION						

DATE	TIME	PRESCRIBER SIGNATURE	STAMP		RPh

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES

DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
INDICATION						
2						
DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
INDICATION						
DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
INDICATION						

DATE	TIME	PRESCRIBER SIGNATURE	STAMP		RPh

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	349 06 0262	NICU	NKA

DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
COMPAZINE	60 mg	PO	QD	7d		
INDICATION						
1 CHRONIC PAIN MGT						
DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
PROVIGIL	200 mg	PO	QAM	7d		
INDICATION						
CHRONIC PAIN MGT						
DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
OXYCONTIN SR	20 mg	PO	BID	7d		
INDICATION						
CHRONIC PAIN MGT						

Roslynn Glicksman, MD

DATE	TIME	PRESCRIBER SIGNATURE	STAMP		RPh
6/6/06		[signature]	0264		

Write medication orders beginning from bottom of page

Chart Copy-White; Pharmacy Copy-Yellow

NYC 0000072

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CHS FORM 8

MEDICATION ORDER SHEET

USE BALL POINT PEN AND PRESS FIRMLY

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	349060262 8	NIC D8	NKA

DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
COMPAZINE	60 mg	PO	QD	7d		
INDICATION: CHRONIC PAIN MGT						
PROVIGIL	200 mg	PO	QAM	7d		
INDICATION:						
OXYCONTIN	20 mg	PO	BID	7d		
INDICATION:						

DATE 6/21/06 TIME | PRESCRIBER SIGNATURE | STAMP: Roslynn Glicksman, MD / Thomas Schwaner, PA #864 | RPh

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	349060262 8	NIC D2	

DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
COMPAZINE	60 mg	PO	QD	7d		
INDICATION:						
PROVIGIL	200 mg	PO	QAM	7d		
INDICATION:						
DRUG:	DOSE:	ROUTE:	FREQUENCY: Marie [illegible] 8/15	DURATION:	NURSE:	DATE/TIME:
INDICATION:						

DATE 5/30/06 TIME | PRESCRIBER SIGNATURE | STAMP: Thomas Schwaner, PA #864 / Roslynn Glicksman, MD | RPh

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	349060262 8	NIC D3	

DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
LIDOCAINE PATCH	1	TOPICAL	QD	30d		
INDICATION:						
(1) NEURONTIN	1000 mg	PO	TID	30d		
INDICATION:						
OXYCONTIN SR	20 mg	PO	BID	7d		
INDICATION:						

DATE 5/31/06 TIME | PRESCRIBER SIGNATURE | STAMP: Thomas Schwaner, PA #864 / Roslynn Glicksman, MD | RPh

8/15 Marie [illegible]

Write medication orders beginning from bottom of page.

Chart Copy–White; Pharmacy Copy–Yellow

CHS (8/94)

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

D3 Elmhurst on 5/26

Patients' Name REYES, JASON DOB 1/13/83

FROM NIC D3, 349 0602628
Correctional institution Inmate no.

Referred to MENTAL HEALTH Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

23 YO M PMHx of REFLEX SYMPATHETIC DYSTROPHY CHRONIC PAIN + DIFFICULTY IN PREVIOUSE HEALTH PATIENT FEELS SAD AT TIMES RISK FOR DEPRESSION

Date 5/25/06 Referring Physician [signature] PA Thomas Schwaner, PA Phone ________ Roslynn Glicksman, MD Approved 5/26/06

Consultation, findings and recommendations:

Pt. out to EHPW on 5/26/06

Pt. at EHPW 5/27/06. [illegible]

5/30/06 7:30pm Pt seen today by mental Health full psychiatric hx of comprehensive Tx plan done — will f/up —

C. [illegible], ac HC

Date ________ Physician ________

HS 2014 (Rev. [illegible])

Reminder: Fully Complete the Problem List

NYC 0000074

New York City Department of Health and Mental Hygiene

PATIENT REFUSAL OF TREATMENT

Patient Addressograph

B.H. NFUJLO PEN
SEYMOUR

Reyes Jason 3420602628

CHS FORM C

This is to certify that I am over the age of 18 years and I am refusing the following:

- ☐ Medical Evaluation [History and Physical]
- ☐ Medical Services
- ☐ Administration of Medication (other than psychiatric)
- ☐ Laboratory Services
- ☐ Diagnostic Testing
- ☐ Other ______
- ☐ Mental Health Evaluation
- ☐ Mental Health Services
- ☐ Administration of Psychiatric Medication
- ☐ X-ray Services
- ☒ Clinic Appointment at BUH

I understand this refusal is against the advice of my health care providers. I acknowledge that I have been informed of the risks, consequences and the danger to my health and possibly to my life which may result from my refusal of this procedure / treatment.

I have been given time to ask questions about my condition and about my decision to refuse the procedure/ treatment which my health care provider has explained to me is medically indicated and necessary.

I voluntarily assume the risks and accept the consequences of my refusal of the procedure/treatment and I am releasing all of the health care providers, the facility and its staff from any and all liability for ill effects that may result from my refusal of treatment.

pt was not able to sign because of hand checking, DOC form signed

Signature of Patient

6/1/06
Date

Two Witnesses: I, Clothen Willm am health care staff member who is not the patient's health care provider for this procedure and I have witnessed the patient voluntarily sign this form.

[signature]
Signature and Title of Witness

I, ______ am not the patient's health care provider for this procedure and I have witnessed the patient voluntarily sign this form.

Signature and Title of Witness

Interpreter/ Translator: [To be signed by the interpreter/translator if the patient require such assistance] To the best of my knowledge the patient understood what was interpreted, translated and voluntarily signed this form.

Signature of Interpreter/ Translator

CHS FORM C

REFUSAL OF TREATMENT PROGRESS NOTE

(The Refusal of Treatment Form C on the reverse side must also be completed)

Patient Addressograph

On 6/1/06 (Date), the above-named patient refused the treatment procedure which is medically or psychiatrically indicated and necessary. I explained the risks, consequences and danger to the health and possibly the life of the above-named patient.

As I explained to the patient, the risks, consequences and dangers of refusing the treatment, procedure include but are not limited to:

Pt refuses clinic appt w BVH TKA
Risk + Benefits + Alternatives explained, pt states
he can not go today but he agrees to be rescheduled
f/u PA/MD TKA

I provided the above-named patient with the opportunity to ask questions. I have answered the questions asked and it is my professional opinion that the patient understands what I have explained.

Signature of Attending Physician or Authorized Health Care Provider[1]

6/1/06
Date

Habib Kamkhaji, MD
Print Name and Identification Number

[1] Authorized Health Care Provider is one who is credentialed and privileged by the medical staff to perform the diagnostic test, procedure or surgery that requires informed consent. See also HHC Consent Policy Article III

CHS 205 (Rev. 2004)

Elmhurst Hospital Center
Discharge/Transfer Summary
79-01 Broadway Elmhurst, New York 11373

Discharge/Transfer Summary

Patient:	Reyes,Jason	DOS:	05/27/06
MR - V#:	2703710-1	Report Date:	05/27/06
DOB/Age/Sex:	01/03/83 23Y M		
Order Author:			
Location:	B4-11 01		

Unscheduled Discharge/Transfer Summary
Event Time: Sat, 27 May 06 0851 Status: complete

Sat, 27 May 06 1014 Documented by Ching Hung Chang, MD

Admit Date : Thu, 25 May 2006
Disposition : Discharge
Discharge Date : Sat, 27 May 2006
Discharge Location : Rikers
Patient Condition : stable
Adm BP : 130/103 mm Hg
Adm Pulse : 117 bpm
Adm Resp : 21
: 189 lbs 0 oz (85729 g, 86 kg)
: 5'8" (68 in, 173 cm)
CC/HPI : Chest Pain 23 yo M with chest pain radiating to his back .
Adm Appearance : Abnormal tremulous, appears uncomfortable
Adm HEENT : Normal
Adm Cardiac : Normal PMI, S1 S2 no murmurs, gallops or rubs
Adm Periph Vasc : Dorsalis pedis pulse +2
Adm Pulmonary : Clear to auscultation
Adm Abdomen : +BS, no rebound or guarding
Adm Skin : No rashes, lesions or ulcers
Adm MSK/Extremities: pain in left lower extremity to palpation
Adm Neurological : Normal
BP : 116/70 mm Hg
Pulse : 79 bpm
Resp : 16
Temp : 97 F (36 C)
Appearance : Normal
Cardiac : Normal PMI, S1 S2 no murmurs, gallops or rubs
Pulmonary : Clear to auscultation
Abdomen : +BS, no rebound or guarding
MSK/Extremities: pain when pressing of chest lateral to sternum

REPORT COPY

Elmhurst Hospital Center
Discharge/Transfer Summary
79-01 Broadway Elmhurst, New York 11373

Discharge/Transfer Summary

Patient:	Reyes,Jason		
MR - V#:	2703710-1	DOS:	05/27/06
DOB/Age/Sex:	01/03/83 23Y M	Report Date:	05/27/06
Order Author:			
Location:	B4-11 01		

Unscheduled Discharge/Transfer Summary -- cont'd

Hospital Course: Pt was admitted to telemetry, was r/o for MI w/ cardiac enzymes x 3. Pt had diffuse t wave inversions on his EKG, cardiology read as interventricular conduction delay, unlikely ischemia. Pt underwent an ECHO to r/o congental heart disease and r/o valvular dz or wall motion abnormalities; ECHO was nml. It was determined that pt likely had chostochondritis, was d/c back to rikers w/ motrin and nexium for gastric protection. Pt has a h/o reflex sympathetic dystrophy, was continued on neurontin and percocet as needed for pain.

Allergies - Med : no known allergies
Allergies - Other: no known allergies
Discharge Rx : *Gabapentin 400 mg Capsule take one tablet by mouth twice daily, Esomeprazole Magnesium 20 mg Oral Cap DR take one tablet by mouth daily x 14 days, Ibuprofen 600 mg Tablet take one tablet by mouth every 8 hours x 14 days
Activity : As tolerated.
Diet : Regular
Provider : Lindsey Reese, MD
Attending : Rahul Patel, MD
Diagnosis : Chest Pain
Comment : Pt to return to Rikers, accepting physician Dr. Bashir

I have read and understand the above discharge plan and I understand it is important to follow these instructions.

Patient/Significant Other Signature Jason Reyes

Reviewed by. Thusadaryan
5/27/06.

REPORT COPY

Nursing Division

PATIENT DISCHARGE INFORMATION RECORD

KEYES, JASON
270-37-10X
01/03/1983M-S

Date 5/27/06 Unit BY

After leaving the hospital you will continue the following: (✓ and provide instructions)

✓		
✓	Exercise	As Tolerated.
	Dressing/Wound Care	
	Glucose Testing	
	Cast / Pin Care	
	Weights	
	Tube / Catheter Care	
	Other	

Special Nutrition / Diet Needs
Regular.

COPY GIVEN: ❑ YES ❑ NO

Vaccination:
❑ Pneumovax: Date given: NOT
❑ Influenza: Date given: eligible
❑

Medication (drug information given – purpose and side effects discussed)

Medication Name	Dose	Route	How often	Special Instructions
Gabapentin / cap.	400mg	mouth	twice	daily
ESOmeprazole cap	20mg	mouth	daily	for 14 days
Ibuprofen tabs	600mg	mouth	every 8 hrs	for 14 days.

Follow-up Care:

Appointment for	Date & Time	Location	Appointment for	Date & Time	Location
			Home Care/VNS Referral: ❑ No ❑ Yes: reason		

Social Work Plan (If required):

Have You Smoked In The Last 12 Months ❑ No ❑ Yes

If you wish to quit smoking, Call 334-718 -334 -2550 (English & Spanish) or 334-2237 (Chinese) for Appointment to Smoking Cessation Program

If you have any unusual symptoms or questions Call adult call center at 718-334 – 2920, Obstetrics 334-3150, Children 334-3025.

In case of any of the following, call your physician or come directly to the emergency room:

If you have chest pain call your Physician or come to emergency room

Be sure to bring appointment slip, this record and your medication/s with you on the day of your appointment.

Copy received - be sure to ask if you have any questions:

PATIENT/FAMILY MEMBER

NURSE RN

ELM 227

NYC 0000079

Hospital Center
New York
REYES, JASON 270-37-10X 01/03/1983M-S

REYES, JASON 270-37-10X 01/03/1983M-S

REYES, JASON 270-37-10X 01/03/1983M-S

ADULT DISCHARGE INSTRUCTIONS ADDENDUM

PREVENTION TECHNIQUES for HEALTHY LIFESTYLE

Every person can follow a healthy lifestyle. Here is a list of things you can do to change your lifestyle and reduce your risk for high blood pressure, heart disease, and stroke:

- Eat healthy and nutritious foods
- Lose weight if you are overweight
- Exercise
- Don't smoke
- Limit alcohol and caffeine
- Manage stress
- Get plenty of sleep

Remember if you want to live a healthier life, find out if you have high blood pressure, heart disease or stroke. Talk with your doctor about lifestyle changes. Follow your doctor's advice.

TECNICAS DE PREVENCIÓN por ESTILO DE VIDA SALUDABLE

Toda persona puede observar un estilo de vida saludable. A continuación encontrará una lista de cosas que puede hacer para cambiar su estilo de vida y reducir el riesgo de presion sanguinea alta, insuficiencia cardiaca, y derrame cerebral:

- Ingiera alimentos saludables y nutritivos
- Pierda peso si esta excedido
- Haga ejercicio
- No fume
- Limite el consumo de alcohol y cafeina
- Controle el estres
- Duerma mucho

Recuerde: si desea vivir una vida mas saludable, determine si tiene presión sanguinea alta, insuficiencia cardiaca, o derrame cerebral. Hable con su doctor sobre cambios en su estilo de vida. Siga los consejos del doctor.

HOW CAN YOU TRY TO AVOID GETTING A COLD?

- Wash your hands often. You can pick up cold germs easily, even when shaking someone's hand or touching doorknobs or handrails.
- Avoid people with colds when possible.
- Clean surfaces you touch with a germ -killing disinfectant.
- Don't touch your nose, eyes or mouth. Germs can enter your body easily by these paths.

¿CÓMO PUEDE TRATAR DE EVITAR UN RESFRÍO?

- Lavese las manos con frecuencia. Los gérmenes de la gripe son fáciles de contagiar, incluso mientras le da la mano a alguien o toca picaportes o pasamanos.
- Dentro de lo posible, evite el contacto con personas resfriadas.
- Si estornuda o tose, hágalo en un pañuelo descartable y luego tírelo.
- Limpie las superficies que toca con un desinfectante que mate los germenes.
- No se toque la nariz, los ojos o la boca. Los gérmenes pueden entrar fácilmente en su cuerpo a traves de estas vías.

DEEP VEIN THROMBOSIS (DVT) PREVENTION

Activity Level:
- Increasing your activity by walking and being active reduces the risk of developing a blood clot.
- Prolonged riding in a car, bus, train or plane may increase your risk of a blood clot.
- When sitting, put your legs up on a pillow, and do not cross your legs or ankles.
- When lying down, do not cross your ankles.

Smoking Cessation:
- If you smoke, stop!
- Think about joining a smoking cessation program.

PREVENCIÓN DE LA TROMBOSIS VENOSA PROFUNDA

Nivel de actividad:
- Aumentar su actividad con caminatas y mantenerse activo reduce el riesgo de desarrollar un coágulo.
- Los viajes prolongados en auto, autobús, tren o avion pueden aumentar el riesgo de formacion de un coágulo.
- Cuando se siente, ponga las piernas sobre una almohada y no cruce las piernas o tobillos.
- No cruce los tobillos al acostarse.

Dejar de fumar:
- Si fuma, ¡deje de hacerlo!
- Piense en unirse a un programa para dejar de fumar.

HEART FAILURE SYMPTOMS	ACTION
• Stable weight / No new symptoms	No Action
• Sudden weight gain (3 or more pounds in one day, 5 or more pounds in one week) • Shortness of breath / Swelling of legs • Trouble sleeping (waking up short of breath) • Frequent dry hacking cough / Fatigue	Call your doctor to Adjust meds
• Chest pain or heaviness • Dizziness or fainting • Persistent difficulty in breathing	Call 911

SINTOMAS DE INSUFICIENCIA CARDIACA	ACCION
• Peso estable/ Sin sintomas nuevos	Ninguna accion
• Repentino aumento de peso (3 libras o mas en un dia, 5 libras o más en una semana) • Falta de aire / Piernas hinchadas • Dificultad para dormir (despertar por falta de aire) • Tos seca frecuente / Fatiga	Llame a su medico para ajustar la medicacion
• Dolor u opresion en el pecho • Mareos o desmayos • Dificultad persistente para respirar	Llame al 911

If patient is unable to sign, please sign and print name and relationship to patient.

[signature]
PATIENT/FAMILY MEMBER

Si el paciente no puede firmar, escriba y firma nombre y relación al paciente.

[signature] RN
NURSE

ELM 2/06 ADDENDUM English Spanish 1/08
Adult Discharge Instructions Addendum English Spanish

ORIGINAL-PATIENT

NYC 0000080

This prescription is valid for non-controlled substances only.
The issuing facility is exempt from the NYS Official Rx Program.

Elmhurst Hospital Center
79-01 Broadway
Elmhurst, NY 11373 Tel: (718) 334-4000 MMIS: 246075

Prescriptions filled by EHC will be filled generically as directed

Date of Rx: 27 May 06

MR # : 2703710
Pt. Name: Reyes,Jason
Address : 1515 Hazen St.
East Elmhurst, NY 11370
DOB : 03 Jan 1983 Loc: B4-11 01

Reese,Lindsey, MD
NY Lic #:
Clinic : _____

Rx: Motrin (Ibuprofen 600 mg Tablet)

600 mg tab by mouth
q8h at default 0600/1400/2200

Disp. Qty: 42 L Reese _____ (signature)

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES 'd a w' IN THE BOX BELOW

☐ **Dispense As Written**

ORIGINAL Rx - Number of Refills: 0

Lindsey Reese, MD
Dlc. code 63126
917-649-1629

This prescription is valid for non-controlled substances only.
The issuing facility is exempt from the NYS Official Rx Program.

Elmhurst Hospital Center
79-01 Broadway
Elmhurst, NY 11373 Tel: (718) 334-4000 MMIS: 246075

Prescriptions filled by EHC will be filled generically as directed

Date of Rx: 27 May 06

R # : 2703710
Pt. Name: Reyes,Jason
Address : 1515 Hazen St.
East Elmhurst, NY 11370
DOB : 03 Jan 1983 Loc: 34-11 01

Reese,Lindsey, MD
NY Lic #:
Clinic : _____

Rx: Nexium (Esomeprazole Magnesium 20 mg Oral Cap DR)
20 mg DR Cap by mouth daily at default 1000

Disp. Qty: 14 L Reese
_____ (signature)

THIS PRESCRIPTION WILL BE FILLED GENERICALLY
UNLESS PRESCRIBER WRITES 'd a w' IN THE BOX BELOW

Dispense As Written

ORIGINAL Rx - Number of Refills: 0

Lindsey Reese, MD
Dic. code 63126
917-649-1629

This prescription is valid for non-controlled substances only.
The issuing facility is exempt from the NYS Official Rx Program.

/

Elmhurst Hospital Center
79-01 Broadway
Elmhurst, NY 11373 Tel: (718) 334-4000 MMIS: 246075

Prescriptions filled by EHC will be filled generically as directed

Date of Rx: 27 May 06

R # : 2703710
Pt. Name: Reyes, Jason
Address : 1515 Hazen St.
East Elmhurst, NY 11370
DOB : 03 Jan 1983 Loc: B4-11 01

Reese, Lindsey, MD
NY Lic #:
Clinic : _____

Rx: Neurontin (*Gabapentin 400 mg Capsule)

800 mg cap by mouth
bid at default 1000/1800

Disp. Qty: 60

_____ (signature)

THIS PRESCRIPTION WILL BE FILLED GENERICALLY
UNLESS PRESCRIBER WRITES 'd a w' IN THE BOX BELOW

Dispense As Written

ORIGINAL Rx - Number of Refills: 0

Lindsey Reese, MD
Dic. code 63126
917-649-1629

3490602629 5/25/2006 12:23:32 PM reyes, jason
Born 1/13/1993 Male Race: Hispanic

BP: 134/74-16-62-55'

PHS (1)

. SINUS RHYTHM.....normal P axis, V-rate 50- 99
. ABNORMAL T, PROBABLE ISCHEMIA, WIDESPREAD.....T <-0.50mV, ant/lat/inf

Rate	90
PR	152
QRSD	86
QT	360
QTc	440

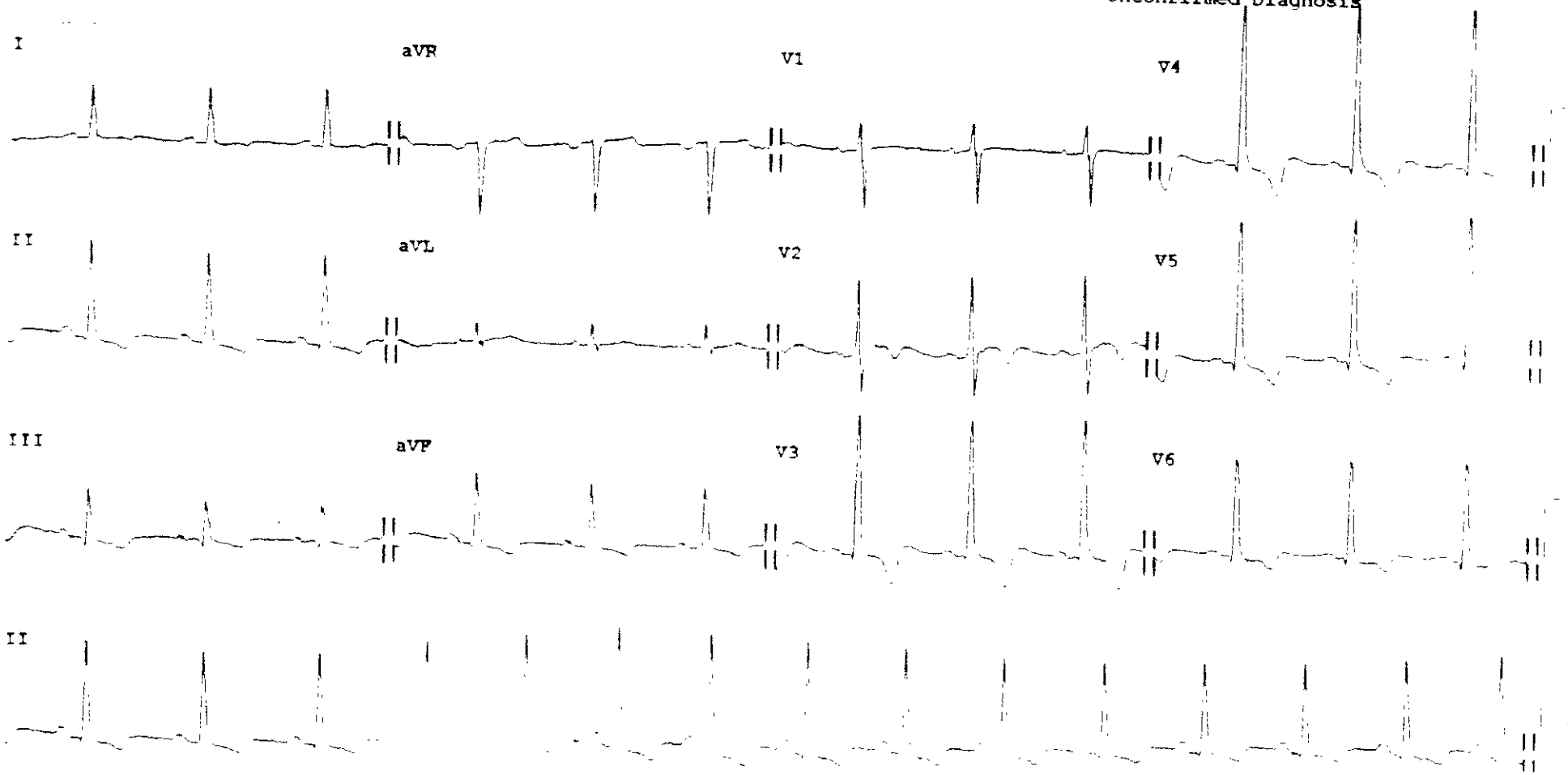
--AXIS--

P	62
QRS	55
T	263

Fac: LOANER

- ABNORMAL ECG -

Unconfirmed Diagnosis



NYC 0000084

Dev: 10009572 Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10 mm/mV 60~ 0.15-150 Hz PH080A

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE CHS FORM

MEDICATION ORDER SHEET

USE BALL POINT PEN AND PRESS FIRMLY

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES

DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
INDICATION						
3						
DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
INDICATION						
DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
INDICATION						

DATE	TIME	PRESCRIBER SIGNATURE	STAMP		RPh

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
Reyes	JASON	349662628	D3	¢

DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
Gabapentin	400 mg	Po	BID	30 day		
INDICATION						
2						
DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
Protonix	40 mg	Po	qD	30 day		
INDICATION						
DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
Ibuprofen	600 mg	Po	q 8hrs	14 day		
INDICATION						
pain						

DATE	TIME	PRESCRIBER SIGNATURE	STAMP		RPh
5/27	8:00 PM				

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
~~Jatley~~	~~Evert~~			

DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
INDICATION						
1						
DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
INDICATION						
DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
INDICATION						

DATE	TIME	PRESCRIBER SIGNATURE	STAMP		RPh

Write medication orders beginning from bottom of page
Chart Copy–White; Pharmacy Copy–Yellow

NYC 0000085

Hospital Transfer Form

Please use ball point pen and print legibly.

Referring DOC Facility: NI 03

Name of referring MD _____ (Please Print)

Hospital Run: ☐ EMS ☐ DOC: ☐ 3 hr. MD Phone # _____

Date: _____ Time: _____ AM/PM

Referred to: ☐ KCHC ☐ Elmhurst ☐ Bellevue

☐ Other: _____

Patient Name: _____

B&C #: _____ DOB: _____ (Please Print)

Contact Urgicare if you have questions: **Beeper# 917-949-1234**
Phone# 718-546-4333

COMPLAINT:

PE

PMH:

Studies/Labs

MEDS

Tx@RI

Allergies:

Significant ED findings/studies:

Discharge Dx:

Recommended FU:

Fax completed form to Urgicare Center @ time of discharge - 718-546-4382

Physician Name **(print)** _____ Signature: _____ Date: _____

Phone # _____

CONTACT URGICARE IF YOU HAVE QUESTIONS / INFORMATION.

FOR BOROUGH HOUSES CONTACT REFERRING PRACTITIONER (ABOVE).

BEEPER #: 917-949-1234
PHONE #: 718-546-4333

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name REYES, JASON DOB 1/13/82

FROM NIC 03 / 349060262A
Correctional institution Inmate no.

Referred to PT Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

PL

23 YOM WAS REFERRED TO PT 5/4/06 FOR R SD IMPINGEMENT SEEN 5/04 FOR 1 MO PER YOUR REQUEST

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

TREAT

Date 5/17/06 Referring Physician Thomas Schwaner, PA Phone

Approved Rosalynn Glicksman, MD

Consultation, findings and recommendations:

Pt to PT c/o pain, impaired posturing, positional malalignment, transfers, basic mobility 20 to GSW c resulting RSD S/S to (L) foot (see eval 5/4/06) pt is to be treated for S/S; will be observed for spontaneous recovery in addition; PAIN 5/10 S/S

Date 5/22/06 Physician [signature] MS P.T.

HS 5011 (Rev. 5/04) *Reminder: Fully Complete the Problem List*

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CHS FORM B

MEDICATION ORDER SHEET

USE BALL POINT PEN AND PRESS FIRMLY

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
3							
	INDICATION						
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
	INDICATION						
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
	INDICATION						

DATE	TIME	PRESCRIBER SIGNATURE	STAMP		RPh

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	34906028	NIC 03	

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
	DIC MS CONTIN						
2	INDICATION						
	OXYCONTIN	20 mg	PO	BID	7d	LM	5/25/06
	INDICATION						
	BLUE STAR AM DOSE						
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
	INDICATION						

DATE	TIME	PRESCRIBER SIGNATURE	STAMP		RPh
5/25/06		PA	Thomas Schwaner, PA	0864	Faisal Ali, MD

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	34906028	NIC 03	NKA

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
	MS CONTIN	15 mg	PO	BID	7d		
1	INDICATION						
	CIMETIDINE	60 mg	PO	QD	7d		
	INDICATION						
	PEN BLK PAIN MGT						
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
	PROVIGIL	200 mg	PO	QAM	7d		
	INDICATION						
	PAIN MGT						

DATE	TIME	PRESCRIBER SIGNATURE	STAMP		RPh
5/22/06		PA	0864		Marie [illegible] 0715

Thomas Schwaner, PA

Write medication orders beginning from bottom of page

Chart Copy--White; Pharmacy Copy--Yellow

CHS [illegible]

NYC 0000088

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CHS FORM E

MEDICATION ORDER SHEET

USE BALL POINT PEN AND PRESS FIRMLY

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	349060262	9 NIC 03	NKA

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
3	HC CREAM	1%	TOPICAL	BID PRN	14d		
	INDICATION						
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	OXYCONTIN						
	INDICATION						
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	MS CONTIN	15mg	PO	BID	7d		
	INDICATION						

DATE	TIME	PRESCRIBER SIGNATURE	STAMP	RPh
5/18/06	0715	Marie J. Robert-Georges, MD Lic #198367	0567 Thomas Schwaner, PA	

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	349060262	5 NIC 08	NKA

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
2	LINOLEAF CATCH	1T	topical	QD	30d		
	INDICATION						
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	NEURONTIN	1000mg	PO	TID	30d		
	INDICATION						
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	INDICATION						

DATE	TIME	PRESCRIBER SIGNATURE	STAMP	RPh
5/17/06			0564 Thomas Schwaner, PA	DW 'Hi Tesley

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	349060262	8 NIC 03	NKA

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
1	OXYCONTIN	20mg	PO	BID	7d		
	INDICATION						
	PER BH PAIN MGR						
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	CYMBALTA	60mg	PO	QD	7d		
	INDICATION						
	PER BH PAIN MGR						
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	PROVIGIL	200mg	PO	QAM	7d		
	INDICATION						
	PER BH PAIN MGR						

DATE	TIME	PRESCRIBER SIGNATURE	STAMP	RPh
5/17/06			Thomas Schwaner, PA	Faisal Ali, MD

Write medication orders beginning from bottom of page

Chart Copy–White Pharmacy Copy–Yellow

CHS (6-2004)